VTED: 04/07/2011 ORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES 3 NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES 2011 ISTR**IGTR**N ATE SURVEY (X1) PROVIDER/SUPPLIER/GLIA (X2) MULT STATEMENT OF DEFICIENCIES OMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDIN C Division of Health Care B WING 03/24/2011 185217 outhern Enforcement Branch Bakess, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER. 701 SKYLINE DRIVE, PO BOX 115 METCALFE HEALTH CARE CENTER EDMONTON, KY 42129 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES D (X4) ID EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 | The preparation and execution of this plan of F 000 INITIAL COMMENTS correction does not constitute admission or agreement by the provider of the truth of the An abbreviated standard survey (KY15993) was facts alleged or conclusions set forth in the conducted on March 23-24, 2011. The allegation was substantiated. Deficient practice was statement of deficiency. This plan of correction identified at a 'G' level, with an opportunity to is prepared and executed solely because it is correct. required by federal and state law. 483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282 F 282 4/8/11 1. Resident #1 received treatment at the hospital PERSONS/PER CARE PLAN SS=G upon verification of the x-ray results. An investgation into the circumstances of the injury to The services provided or arranged by the facility must be provided by qualified persons in Resident #1 was conducted by the Administrator accordance with each resident's written plan of and DON upon identification of the injury findings, сэге with notification of DCBS and the OIG. Review of the status of Resident #1 was conducted with This REQUIREMENT is not met as evidenced the family, with review/revision of the care plan and patient record to include bed baths for bathing Based on interview and record review it was and mechanical lift for all transfers. determined the facility failed to provide services in 2. All residents requiring the use of a mechanical accordance with each resident's plan of care for lift have been evaluated to determine appropriate one of three sampled residents (resident #1). The facility failed to utilize a mechanical lift to lift use. Findings were reviewed with the residents/ transfer resident #1 for bathing on February 20, families with review/revision of the care plans 2011, in accordance with the resident's plan of and patient care records to address lift use as care, resulting in pain and injury to the resident's indicated. right knee. Resident #1 was diagnosed with a 3. Licensed and non-licensed nursing staff have fracture to the right tibia and fibula (below the received in-service education on the provision right knee) on February 22, 2011. of transfer assistance for residents in accordance The findings include: with the care plan and patient care record, including but not limited to the proper use of A review of the medical record for resident #1 the mechanical lift, as provided by the DON/ revealed the resident was admitted to the facility on October 6, 2004, with diagnoses that included ADON/Staff Development on 2/24, 3/2, 3/7, severe Osteoporosis, Osteoarthritis, a history of 3/16, 3/21, 3/23, 3/24, 3/25, 3/26, 3/27, 3/28, Fractured Vertebrae, and Lumbar Compression. 3/30, 3/31, and 4/6. A review of resident #1's annual Minimum Data Set (MDS) dated April 8, 2010, revealed the TITLE (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUR

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 100470

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			71	EET ADDRESS, CITY, STATE, ZIP CODE 01 SKYLINE DRIVE, PO BOX 115 DMONTON, KY 42129		-	
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F 282	facility assessed re assistance of two or transfers. A review comprehensive car 2010, an interventional transfers was accare. A review of the Care Plan record for staff persons were transfers for reside. A review of nurse's 2011, at 12:45 p.m yelling in pain and redema to the right physician and responders were received to the factor of	sident #1 to require total or more staff persons for of the resident's re plan revealed on April 5, on for the use of a Hoyer lift for ided to the resident's plan of the Certified Nurse Aide (CNA) or February 2011 revealed two to use a mechanical lift for all nt #1. In notes dated February 22,, revealed resident #1 was was noted to have redness and leg and right knee. The onsible party were notified and ed to transfer resident #1 to the cion and treatment. Resident facility on February 22, 2011, at of the hospital record revealed agnosed with fractures of the	F		4. Observations of non-licensed nur implementation of interventions in with the care plan/patient record with by the DON/ADON/Staff Developed dinator on 2 staff per day x 1 week, per week x 2 weeks, and then using Indicator as outlined. The CQI Indicate monitoring of implementation of in accordance with the care plan/parecord will be utilized monthly x 2 then quarterly as per the established under the supervision of the Directors.	accordance Il be comple nent Coor- then 2 staff the CQI cator for of intervention tient care months, and	ns ar,
	resident #1's fracturevealed the facility leg was injured dur CNAs #1, #2, and a Hoyer lift to trans was reported to stathree CNAs transfeuse of a lift on Feb An interview conducts, 2011, at 2:35 pc 2011, CNA #3 requand CNA #2 to transfer bathing. CNA #	itity's investigation regarding tres dated February 23, 2011, what determined resident #1's ring a transfer conducted by #3 when the CNAs did not use after the resident. The resident ate, "Oh, my knee," when the erred resident #1 without the ruary 20, 2011. Incted with CNA #1 on March are the resident #1 to a lift chair #1 stated a sitting transfer with eat from a geri-chair to a bath					

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i	NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			7	REET ADDRESS, CITY, STATE, ZIP CODE 101 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129		
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F 282	chair/lift was compassistance of CNA: transfer resident # saying, "Oh, my kn not complain at any resident was transfafter the bath was with CNA #1 revea always utilized for a Hoyer lift was util resident #1. An interview conducted in the conducted in the cNA # 1.	eted for resident #1 with the s #1, #2, and #3. During the f was noted to complain by ee." However, the resident did y other time or when the ferred back to the geri-chair complete. Additional interview led this method of transfer was resident #1 for bathing and that ized for all other transfers for acted on March 23, 2011, at A #3, whose primary duty was	F:	282			
	to bathe residents, 2011, CNA #3 request and #2 to transite a bath/lift chair figait belt and three-transfer the residency complaints frough transfer. CNA #3 assessed to require transfers. However Hoyer lift when transtents, CNA #3 but the shower rochad always been to	revealed on February 20, uested the assistance of CNAs fer resident #1 from a geri-chair or bathing. CNA #3 stated a person assist was utilized to nt. CNA #3 was not aware of m resident #1 during the was aware resident #1 was e a mechanical lift for all er, staff had never utilized a nsferring resident #1 for stated the lift could be utilized on was small and resident #1 ransferred with the use of three					
Management of the second of th	23, 2011, at 3:06 p 2011, CNAs #1, #/ #1 from a geri-cha a gait belt. CNA # turned during the t my knee." CNA #/ further complaints	ucted with CNA #2 on March o.m., revealed on February 20, 2, and #3 transferred resident iir to a bath/lift chair by utilizing 2 stated when resident #1 was ransfer resident #1 said, "Oh, 2 stated resident #1 had no after the transfer, during the sferred after the bath was					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C	
,		185217	B, WING	,		/2011
NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			70	EET ADDRESS, CITY, STATE, ZIP CODE 11 SKYLINE DRIVE, PO BOX 115 DMONTON, KY 42129		
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F 282	never been utilized transfers. An interview conduction 2011, at 1:50 p.m., required to be utilized and ensured according to each thowever, the LPN utilizing a lift to transferring results between the conduction to be utilized transferring the results of the conduction to be utilized transferring the results of the conduction to the conduction	age 3 2 reported a Hoyer lift had for resident #1 during bathing acted with LPN #1 on March 23, revealed that a lift was acted when transferring resident sident was dead weight and ent may hurt the resident. acted each shift to monitor a resident care was provided resident's plan of care. was not aware staff was not insfer resident #1 for bathing. ware staff was not utilizing a lift ident #1 during bathing on when the CNAs requested betained for showers instead of a first the because of the resident's view revealed the LPN son February 20, 2011, that a for resident #1 when sident for bathing. The LPN Director of Nursing (DON) that and the lift on February 21,	F 282			
Managagagaga panaganan na	Nursing (DON) on revealed resident a use of a mechanic of the resident's se stated the nurses resident baths dail ensure the care we resident's plan of a the CNAs were chiransfers by a pred	ucted with the Director of March 23, 2011, at 3:15 p.m., If was assessed to require the al lift for all transfers because evere osteoporosis. The DON were required to monitor y when making rounds to as provided according to the care. Further interview revealed ecked off on bathing and exptor upon hire and annually to were knowledgeable regarding				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		185217	B. Wil	1G —		03/24	J/2011
	NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			70	REET ADDRESS, CITY, STATE, ZIP CODE 01 SKYLINE DRIVE, PO BOX 115 DMONTON, KY 42129		
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F 282 F 323 SS=G	resident care. The not utilizing the Hoy for bathing per the February 21, 2011. fractured tibia and according to the fac 483.25(h) FREE OI HAZARDS/SUPER The facility must er environment remai as is possible; and adequate supervisi prevent accidents. This REQUIREME by: Based on interview determined the fac three sampled resi adequate supervisi prevent accidents. #1 to require the us transfers. Howeve without the use of 2011. The resident during the transfer, fracture to the fibia knee) on February resident's medical revealed staff was	DON was not aware staff was ver lift to transfer resident #1 resident's plan of care until Resident #1 sustained a fibula during this incident cility investigation. FACCIDENT VISION/DEVICES asure that the resident hazards each resident receives on and assistance devices to was as free of accident hazards each resident receives on and assistance devices to the facility failed to ensure one of dents (resident #1) received on and assistive devices to the facility assessed resident #1 a Hoyer lift on February 20, it complained of right knee pain and was diagnosed with a and fibula (below the right 22, 2011. Review of the record and staff interview required to utilize a Hoyer lift esident #1 to ensure safe issident.		323	1. Resident #1 received treatment at upon verification of the x-ray results gation into the circumstances of the Resident #1 was conducted by the A and DON upon identification of the with notification of DCBS and the Of the status of Resident #1 was conthe family, with review/revision of and patient record to include bed ba and mechanical lift for all transfers. 2. All residents requiring the use of lift have been evaluated to determin lift use. Findings were reviewed with families with review/revision of the and patient care records to address I indicated. 3. Licensed and non-licensed nursing received in-service education on the of transfer assistance for residents in with the care plan and patient care including but not limited to the profit mechanical lift, as provided by ADON/Staff Development on 2/24, 3/16, 3/21, 3/23, 3/24, 3/25, 3/26, 3 3/30, 3/31, and 4/6.	s. An invest- injury to Administrato injury findin DIG. Review aducted with the care plan ths for bathi a mechanica te appropriate th the resides care plans lift use as the provision accordance record, per use of the DON/ 1, 3/2, 3/7,	r ngs, ng il æ

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AND PLAN OF CORRE	ECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING			!
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Revier reveal on October seven Fractu A revier reside facility assist transful #1 revier mech belt at the categories.	led the reside tober 6, 2004 a Osteoporos ured Vertebra ew of a Minin ant #1 dated A assessed thance of two ders. A review realed an interesisted transfare plan on June 1904	ical record for resident #1 int was admitted to the facility it, with diagnoses that included is, Osteoarthritis, a history of e, and Lumbar Compression. num Data Set (MDS) for April 8, 2010, revealed the e resident to require total or more staff persons for of the care plan for resident ervention for the use of a ed April 5, 2010, and that a gait for had been discontinued from one 29, 2010. visician's orders for February	F3	implem with the by the dinator per were Indicate the more in according to the north the more than th	ervations of non-licensed numeritation of interventions in ecare plan/patient record we DON/ADON/Staff Develope on 2 staff per day x 1 week ek x 2 weeks, and then using or as outlined. The CQI Indinitoring of implementation ordance with the care plan/pawill be utilized monthly x 2 marterly as per the establishes the supervision of the Direct	accordance ill be comple ment Coor- , then 2 staff g the CQI icator for of intervention attent care months, and d CQI calend	ns ar,
2011 for all A revion Fe was r redne knee. transi treatn Febru of fra	revealed a m transfers for iew of nurse's abruary 22, 20 toted to be in ess and edem The nurse's ferred to the languary 22, 2011 cture to the beauty of the facil	echanical lift was to be utilized					
reside cause CNAs lift du Inten Regis	ent #1's right ed when resid s #1, #2, and ring a bath or riew conducte stered Nurse	leg were determined to be lent #1 was transferred by #3 without the use of a Hoyer in February 20, 2011. Ed with the Advanced Practitioner (ARNP) on March					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
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	NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			REET ADDRESS, CITY, STATE, ZIP CODE 101 SKYLINE DRIVE, PO BOX 115 E DMONTON, KY 42129		-
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F 323	mechanical lift had resident #1 the mechanical forms in the resident #1 the re	age 6 I been utilized to transfer sident would have been less injured. The ARNP stated the sical lift would have applied re during the transfer. Per be difficult for three staff sident with even pressure d not lift at the exact same ucted with CNA #1 on March o.m., revealed on February 20, sisted CNAs #2 and #3 with the it #1 from a geri-chair to a A #1 stated resident #1 in the transfer by saying, "Oh, my resident #1 did not complain at ing care or when the resident ack to the geri-chair after the	F 323			
	bath was completed resident #1 required However, CNA #1 transferred for bath and three staff per An interview cond 23, 2011, at 2:48 primarily responsi #3 provided a bath 2011, and had transsistance of CNA gait belt was utilized from a geri-chair ton February 20, 2 lift. CNA #3 was assessed to require transfers. However, used to transfer resident was a second to transfer resident.	ed. CNA #1 was aware that ed a Hoyer lift for transfers. stated resident #1 was always hing with the use of a gait belt				

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(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			70	EET ADDRESS, CITY, STATE, ZIP CODE 01 SKYLINE DRIVE, PO BOX 115 DMONTON, KY 42129		
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F 323	that resident #1 had the use of three star CNA #3 further star the shower room w stated the concern	d always been transferred with If persons and a gait belt. ted a lift could be utilized, but as small. However, CNA #3 regarding the shower room eported to the facility's	F 323			
	23, 2011, at 3:06 p 2011, CNAs #1, #2 #1 from a geri-chai gait bett. CNA #2: turned during the tr my knee." CNA #2 further complaints bath, or when trans- completed. CNA #	cted with CNA #2 on March .m., revealed on February 20, ., and #3 transferred resident ir to a bath/lift chair utilizing a stated when resident #1 was ransfer resident #1 said, "Oh, a stated resident #1 had no after the transfer, during the sferred after the bath was 12 stated a Hoyer lift had never sident #1 during bathing				
	2011, at 1:50 p.m., assessed to requir the resident was he resident could cause further interview not to make rounds easier providing resident to train to train to the interview not to make rounds easier providing resident to train to provide the course of trainsfer resident #	icted with LPN #1 on March 23, revealed resident #1 was e a lift for transfers because eavy and pulling on the se injury to the resident. evealed the LPN was required ich shift to ensure the CNAs ident care as required, was not aware staff was not insfer resident #1 for bathing, ware staff was not utilizing a fift to bathing on February 20, 2011, quested that an order be ers for resident #1 instead of a of the resident's size. LPN #1 is that a lift was to be utilized to 1 for bathing. The LPN tor of Nursing (DON) that staff				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	URVEY ETED
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F 323	An interview conduntring (DON) on revealed the nurse to make rounds date on the conduction of the cond	e lift on February 21, 2011. Interest with the Director of March 23, 2011, at 3:15 p.m., Is at each station were required inly to monitor resident care and the same providing resident care and the DON stated the CNAs by a preceptor for resident there is upon hire and annually to the supon hire and annually to the provided geable regarding a DON was not aware staff was the plan for resident #1 by the for all transfers, until LPN #1 that the CNAs had not used a ton February 20, 2011. Increase with the facility March 23, 2011, at 5:15 p.m., Iministrative staff made rounds by to ensure care provided to the ropriate. The Administrator the staff and nurses monitored thowever the Administrator was denoted in the second of the the sustained a fractured tibia this incident according to the				